

ATTACHMENT 1.2-B

OAHU APPLICATIONS SECTION

1. Evaluates individual cases to determine medical eligibility.
2. Enrolls eligible individuals in the QUEST program.
3. Interviews applicants and obtains eligibility information and assists in the completion of the required forms.
4. Reviews and determines cases for disability eligibility.
5. Provides educational and informational sessions to the public related to the various medical assistance programs. Encourages prospective applicants to initiate the application process.

OAHU ON-GOING SECTION AND UNITS

1. Evaluates individual cases to determine continued medical eligibility. Adjusts benefits (e.g., increase or decrease premium share amount) based on available resources.
2. Issues eligibility review forms, interviews applicants to update eligibility information and assists in the completion of the required forms.
3. Resolves member problems related to changing health plans. Directs member problems related to access to care or quality of care to the Medical Standards Compliance Section. Assists in the filing of recipient grievances.
4. Maintains member, Medicare and TPL files.
5. Reviews and determines cases for on-going need for disability eligibility.
6. Receives complaints and assists clients in applying for fair hearing. Processes fair hearing reports and participates in hearing.
7. Obtains facts regarding suspected fraud, prepares reports, and testifies in court, if necessary.
8. Investigates the eligibility status of recipients who appear to be ineligible for the medical assistance programs in accordance with established policies and procedures and the applicant's right to confidentiality.

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HEALTH COVERAGE MANAGEMENT BRANCH

Under the direction of the Med-QUEST Division Administrator, the Health Coverage Management Branch manages and carries out the State's QUEST Program, as authorized by a waiver under Section 1115 of Title XIX of the Social Security Act, and the Aged, Blind and Disabled Program.

CLERICAL SUPPORT

Provides stenographic, clerical, and typing services for all segments of the organization.

HEALTH PLAN RELATIONS SECTION

The Health Plan Relations Section is responsible for developing and monitoring relationships with current and prospective Health Plans participating in the QUEST program.

1. Maintains liaison between state and health plans participating in the QUEST program.
2. Administers and coordinates all aspects of contract development and negotiation.
3. Coordinate/direct activities relating to issuance of the RFP and monitoring of contracts with health plans.
4. Coordinates with other Med-QUEST branches and sections to establish/revise minimum qualifications and service delivery standards.
5. Coordinates the development and implementation of the statewide procedures for monitoring the health plans participating in the QUEST program.
6. Works with health plans interested in participating in the QUEST program. Assists with organizing and becoming sanctioned under the QUEST program.
7. Maintains communication with the health plans relating to emerging legislative trends, new programs, changing program objectives and goals, new health plan sanctions, and other matters.

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FINANCIAL RISK ANALYSIS SECTION

The Financial Risk Analysis Section is responsible for analyzing health plan financial information to assess the risks associated with the plan's participation in the QUEST program.

1. Assesses financial feasibility of provider bids to determine levels of financial risk.
2. Establishes the criteria and procedures to be used to evaluate the financial viability of plans submitting bids and to monitor the financial performance of participating plans. Determines information reporting requirements; develops forms, procedures and instructions; establishes reporting timetables; and recommends sanctions. Prepares and maintains documentation of plan financial reporting requirements.
3. Monitors the financial performance of participating plans. Reviews financial information submitted by the plans. Calculates financial ratios and other measures used to evaluate financial performance. Compares plan performances to other plans and industry standards. Determines whether sanctions should be assessed and/or whether plans should be evaluated more frequently. Recommends action on health plans not meeting the state's minimum financial standards.
4. Coordinates with the Planning and Program Development Office in planning, developing and implementing internal and external cost containment measures.

RESEARCH SECTION

The Research Section is responsible for planning, directing, conducting, and coordinating statistical reporting and social research for the QUEST program.

1. Plans, directs, conducts and coordinates research to evaluate the effectiveness of the QUEST program and to test the project hypotheses. Reviews program objectives, identifies appropriate research approaches and designs research projects (e.g., interviews, survey, record analysis, data analysis, etc.) to effectively evaluate the program.

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2. Coordinates with other Med-QUEST personnel to define a standard data set to evaluate the QUEST program. Defines data, establishes collection mechanisms and documents data collection standards for the plans. Evaluates classification and reporting difficulties and develops alternative collection procedures to minimize data reporting differences.
3. Compiles and maintains all data files on the QUEST program. Designs and conducts analytical tests to assure the validity of the data collected on the QUEST program. Edits and updates data files as necessary. Develops and recommends procedures, methods, and requirements to maintain or increase integrity of data, and data bases.
4. Analyzes and interprets data and identifies trends and patterns related to, but not limited to recipients, cost, quality of service, utilization of services and customer satisfaction. Investigates differences between plans, clients, and providers and determines whether data collection and analysis can explain differences.
5. Coordinates collection of enrollment and roster data for health plans and QUEST program contractors.

MEDICAL STANDARDS BRANCH

Under the direction of the Med-QUEST Division Administrator, the Medical Standards Branch develops and maintains the statewide standards for care provided under State's medical assistance programs.

CLERICAL SUPPORT

Provides stenographic, clerical, and typing services for all segments of the organization.

MEDICAL STANDARDS DEVELOPMENT SECTION

The Medical Standards Development Section is responsible for developing the standards for quality medical care by identifying, collecting and analyzing relevant data provided by the Division's various programs.

1. Develops, implements and maintains statewide standards for care provided under the State's medical assistance programs.

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2. Monitors medical, dental, and mental health services provided under the various medical assistance programs.
3. Develops, implements and maintains standards for training, supervision and experience qualifications for medical care providers involved in the State's medical assistance programs. Coordinates with appropriate Division branches to ensure uniform and consistent application of standards.
4. Coordinates with other Division segments to identify and develops changes in the statewide medical standard for care provided under the medical assistance programs.
5. Monitors county, state and federal legislation to identify changes in the standards for medical care provided under the medical assistance program.
6. Conducts, reviews, and determines cases for prior authorization for services in the health care specialties of medicine, psychiatry, dentistry, pharmacy and other related health care services for ABD program.
7. Develops, implements, and monitors statewide policies and procedures for member, provider and contractor grievance investigations and adjudication related to the quality of care provided under the medical assistance programs.
8. Oversees, reviews, and approves all grievance procedures adopted by plans, program contractors and other agencies.
9. Conducts reviews of pre and post payment of health services claims referred by the Fiscal Intermediary, Office of the Administrator and other referrals.
10. Serves as the Division's representative to professional peer review committees, departmental fair hearings and appeals and court hearings.

MEDICAL STANDARDS COMPLIANCE SECTION

The Medical Standards Compliance Section is responsible for ensuring that the Division's quality standards are upheld. The Section monitors the quality of medical care by defining, collecting, and analyzing health plan data.

1. Monitors care provided by health care providers to ensure compliance with Federal and State laws and regulations.

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2. Establishes and monitors measures of quality in accordance with the established HCFA and professional guidelines.
3. Develops regulations and implement policies and procedures relating to long-term quality control and assurance requirements.
4. Renders technical assistance and monitoring of long-term care nursing facilities according to Federal and State requirements.
5. Develops, implements, and coordinates a system of management control and tracking of Medicaid fraud and abuse including the enforcement of contractual agreements with participating providers and works closely with the Attorney General's Office.
6. Develops, implements, and monitors the recipient lock-in and provider lock-out programs.
7. Conducts utilization reviews and reviews other submitted data (outcomes) to evaluate quality of care.
8. Serves on utilization review teams including inspection of care of participating hospitals, clinics and other non-institutional providers.
9. Tracks the number of catastrophic care cases handled, as well as the type of care, quality of care, cost, and outcome of each case to determine the effectiveness of the catastrophic care program.
10. Works with health care consultants to evaluate the services provided by the health plans participating in the medical assistance programs.
11. Reviews recipient complaint forms for accuracy and completeness. Identifies additional data needs as necessary.
12. Reviews client records, client surveys, etc. to evaluate the quality of service in line with established quality measures (patient outcomes, patient mortality, non-fatal complication rates, functional status, return to work rates, and quality of life).

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13. Ensures development, implementation and maintenance of comprehensive internal quality assurance systems by all providers participating in the medical assistance programs, in line with federal regulations and standards. Assists providers in clearly defining: clinical areas to be monitored, use of quality indicators, clinical care standards and practice guidelines, analysis procedures, implementation of remedial/corrective actions, monitoring of remedial/corrective actions, and record keeping standards.

COMMUNITY LONG TERM CARE BRANCH

The Community Long Term Care Branch develops, plans policies and procedures, sets standards, implement and provides overall management of the NHWW program and maintains appropriate Medicaid waivers and other non-Medicaid programs required to provide home and community-based long term care services.

1. Conducts research, analysis and evaluation of the Nursing Home Without Walls program.
2. Obtains medical consultation for the Nursing Home Without Walls staff as required for provision of patient care, development of program protocols, continuing education, and resolution of medical questions, problems and emergencies.
3. Analyzes the educational and developmental requirements of program staff and patient care providers (staff and contractual, professions, paraprofessional and informal) and develops curricula, certification and performance standards to meet these requirements.
4. Coordinates and completes all procedures necessary to provide, evaluate and report on training programs.
5. Assures that all initial, ongoing and special Medicaid eligibility requirements for patients served by Nursing Home Without Walls are maintained.
6. Assures availability of providers of all services utilized by the programs; negotiates contract with vendors of medical and home and community-based services.
7. Monitors and assures quality of services provided by professional, paraprofessional and informal service providers.

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8. Reviews provide service claims and charges to determine compliance with agreements and procedural requirement; coordinates payment and allocation of service costs.
9. Establishes and maintains all policies and procedures for intake, assessment, care planning, service delivery, monitoring, evaluation, discharge and overall case management for patients of the program.
10. Works with providers from other agencies to coordinate referrals and services received by patients of the program.
11. Provides all clerical and office support for the Nursing Home Without Walls staff including reception, typing, duplicating, filing, mail service, messenger service, stenography, supply and equipment inventory services, personnel, payroll and assignment procedural requirements and general clerical support.
12. Develops and maintains cost-effective home and community-based long term care programs to meet the service needs of the non-Medicaid target populations authorized by state statute.

Staff Service Office

Provides clerical support services for statewide community long term care services as they relate to telephone and receptionist duties; filing systems development and maintenance; stenographic and clerical supervision and support; mail and correspondence control; supplies, equipment and space procurement and maintenance, transportation and per diem arrangements; duplicating and production; typing requirements of the program; computerized data input and extraction; fiscal and statistical support; records control; reports generation; and related clerical functions.

Program Operations Section I

1. Implements and provides community long term care services in the City and County of Honolulu.
2. Monitors and assures compliance with the requirements of federally approved waivers, state contracts, rules and procedures for the provision of community long term care services in the City and County of Honolulu.

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3. Generates and implements working agreements with other community agencies providing related services to community long term care recipients in the City and County of Honolulu.

Admissions Unit

1. Accepts all applications for community long term care; screens applicants; determines eligibility and completes termination and admissions procedures; completes initial assessments, develops preliminary care plans, arranges for services and transfers cases to primary and intensive units for on-going case management.
2. Provides liaison with eligibility and payment units of the branches for concerns related to processing of Form 1240 and with state medical consultants for concerns related to the processing of Form 1147.
3. Collects recipient Medicaid cost share; maintains procedures to account for appropriate dispensation of cost share.
4. Collects and compiles data related to applications and admissions to community long term care services.

Primary Case Management Unit

Provides on-going community long term care services to eligible recipients utilizing the primary case management model in the City and County of Honolulu.

Intensive Case Management Unit

Provides on-going community long term care services to eligible recipients utilizing the intensive case management model in the City and County of Honolulu.

Personal Care Unit (P.C. Sub-Unit I & II)

Maintains a pool of part-time intermittent Licensed Practical Nurses and Community Health Aides I, II, and III to provide personal care services to the chronically ill and disabled recipients of community long term care in their own homes in the City and County of Honolulu.

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Program Operations Section II

1. Implements and provides community long term care services in the counties of Hawaii, Kauai, and Maui.
2. Monitors and assures compliance with the requirements and federally approved waivers, state contracts, rules and procedures for the provision of community long term care services in the counties of Hawaii, Kauai, and Maui.
3. Generates and implements working agreements with other community agencies providing related services to community long term care recipients in the counties of Hawaii, Kauai, and Maui.

Hawaii, Kauai, and Maui County Units

1. Accepts all applications for community long term care services from residents of the county; screens applications; determines eligibility and completes termination or admission procedures.
2. Provides liaison with branch units to assure completion of all Medicaid eligibility requirements and with the state medical consultants to assure completion of long term care certification requirements.
3. Provides on-going community long term care services to eligible recipients utilizing the primary and intensive case management models.

Non-Medicaid Section

The Non-Medicaid Section of the Community Long Term Care Branch develops and maintains cost-effective home and community-based long term care programs to meet the service of the non-Medicaid target populations authorized by state statute regarding home and community-based services programs.

1. Provides comprehensive array of services to severely or chronically ill and disabled persons of all ages statewide as an alternative to institutional nursing home care; provides ongoing case management as core service and provides or arranges for such program services as personal care, adult day health, emergency alarm response systems, nutritional counseling, home delivered meals, respite, transportation, home modifications, homemaker and nursing

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